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9
10 **BEFORE THE**
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

11
12 In the Matter of the Accusation Against:

Case No. *2013-209*

13 **ANGELINA LILLY ORTIZ**
40355 Odessa Drive
14 Temecula, CA 92591

A C C U S A T I O N

15 **Registered Nurse License No. 508931**

16 Respondent.

17
18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
21 official capacity as the Executive Officer of the Board of Registered Nursing, Department of
22 Consumer Affairs.

23 2. On or about February 24, 1995, the Board of Registered Nursing issued Registered
24 Nurse License Number 508931 to Angelina Lilly Ortiz (Respondent). The Registered Nurse
25 License was in full force and effect at all times relevant to the charges brought herein and will
26 expire on December 31, 2012, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2052 of the Code states:

(a) Notwithstanding Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars (\$10,000), by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment.

....

(c) The remedy provided in this section shall not preclude any other remedy provided by law.

7. Section 2725 of the Code states:

....

(b) The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:

.....
(2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.
.....

8. Section 2761 of the Code states:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
.....

(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter or regulations adopted pursuant to it.
.....

9. Section 2762 of the Code states:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
.....

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

10. Section 4022 of the Code states

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

1 (b) Any device that bears the statement: "Caution: federal law restricts this
2 device to sale by or on the order of a _____," "Rx only," or words of similar
3 import, the blank to be filled in with the designation of the practitioner licensed to use
4 or order use of the device.

5 (c) Any other drug or device that by federal or state law can be lawfully
6 dispensed only on prescription or furnished pursuant to Section 4006.

7 REGULATORY PROVISIONS

8 11. California Code of Regulations, title 16, section 1443, states:

9 As used in Section 2761 of the code, 'incompetence' means the lack of
10 possession of or the failure to exercise that degree of learning, skill, care and
11 experience ordinarily possessed and exercised by a competent registered nurse as
12 described in Section 1443.5.

13 12. California Code of Regulations, title 16, section 1443.5 states:

14 A registered nurse shall be considered to be competent when he/she
15 consistently demonstrates the ability to transfer scientific knowledge from social,
16 biological and physical sciences in applying the nursing process, as follows:

17 (1) Formulates a nursing diagnosis through observation of the client's physical
18 condition and behavior, and through interpretation of information obtained from the
19 client and others, including the health team.

20 (2) Formulates a care plan, in collaboration with the client, which ensures that
21 direct and indirect nursing care services provide for the client's safety, comfort,
22 hygiene, and protection, and for disease prevention and restorative measures.

23 (3) Performs skills essential to the kind of nursing action to be taken, explains
24 the health treatment to the client and family and teaches the client and family how to
25 care for the client's health needs.

26 (4) Delegates tasks to subordinates based on the legal scopes of practice of the
27 subordinates and on the preparation and capability needed in the tasks to be
28 delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the
client's physical condition and behavior, signs and symptoms of illness, and reactions
to treatment and through communication with the client and health team members,
and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action
to improve health care or to change decisions or activities which are against the
interests or wishes of the client, and by giving the client the opportunity to make
informed decisions about health care before it is provided.

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1 **COST RECOVERY**

2 13. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
3 administrative law judge to direct a licensee found to have committed a violation or violations of
4 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
5 enforcement of the case.

6 **DRUGS**

7 14. Hydromorphone, also known by the brand name Dilaudid, is a Schedule II controlled
8 substance as designated by Health and Safety Code Section 11055, subdivision (b)(1)(J), and is a
9 dangerous drug pursuant to Business and Professions Code section 4022.

10 15. Morphine sulfate (morphine) is a Schedule II controlled substance as designated by
11 Health and Safety Code section 11055, subdivision (b)(1)(L), and is a dangerous drug pursuant to
12 Business and Professions Code section 4022.

13 **Division of Investigation Case No. 11-03184-RN**

14 16. On or about January 12, 2011, the Board received a complaint from a Kaiser
15 Permanente hospital in Anaheim (Kaiser) alleging that Respondent failed to follow policy and
16 procedures in the proper withdrawal and documentation of controlled substances. Respondent
17 had been an employee of Kaiser since January 1989, and was working in the Emergency
18 Department at the time of the incidents described herein.

19 17. Respondent received training in and was responsible for implementing Kaiser's
20 protocols. Specifically, Respondent was responsible for adhering to Kaiser's Patient Care
21 Manual policies and procedures entitled "*Medication Administration Using Pyxis*," "*Medication*
22 *Administration Record Documentation Guidelines*," and "*Medication Administration, Medication*
23 *Expiration, Medication Administrative Schedule*."

24 18. As a result of the complaint, the Division of Investigation (DOI) commenced an
25 investigation of the allegations. The Clinical Director of Emergency Services at Kaiser told the
26 DOI investigator that they became suspicious after a quarterly report indicated that Respondent's
27 controlled substance withdrawals exceeded the norm, specifically for hydromorphone and

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1 morphine. The hospital's narcotic control system had recently transferred from paper records to
2 Pyxis.¹ The matter was referred to Kaiser's pharmaceutical group for investigation.

3 19. After a review of patient records, pharmacy records, and Pyxis reports, the Clinical
4 Director concluded that Respondent administered medications inappropriately. Gaps in
5 Respondent's withdrawal of controlled substances, lack of wastage, and "stacking"² were
6 discovered. Respondent was permitted to retire in lieu of termination. The DOI investigation
7 documented the following discrepancies:

8 20. Patient 3: On June 12, 2010, at 11:31 hours, this patient received a physician's order
9 for 4 mg. morphine. At 11:37, the physician changed the order to 1 mg. hydromorphone.
10 Respondent removed a 10 mg morphine dose from Pyxis at 11:44. At 11:45, Respondent
11 removed a 2 mg hydromorphone dose from Pyxis. Respondent administered 1 mg
12 hydromorphone to the patient at 11:54, and wasted the remaining 1 mg hydromorphone with a
13 witness. Respondent failed to document the patient's pain scale prior to administering the
14 medication. Respondent did not account for the 10 mg morphine she withdrew from Pyxis; it was
15 not documented as administered in the patient's Medication Administration Record (MAR), and it
16 was not wasted. Respondent failed to account for 10 mg. morphine.

17 21. Patient 5: On June 19, 2010, at 14:38, this patient received a physician's order for 1
18 mg. hydromorphone. Respondent withdrew a 2 mg. dose of hydromorphone from Pyxis at 14:58.
19 Respondent documented that 1 mg. hydromorphone was administered in the patient's MAR, and
20 1 mg. was wasted. At 15:03, the physician ordered 2 mg. morphine every four hours as needed
21 for moderate pain, or 4 mg. morphine every four hours as needed for severe pain. Respondent

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23 ¹ "Pyxis" is a trade name for the automatic single-unit dose medication dispensing system
24 that records information such as patient name, physician orders, the date and time the medication
25 was withdrawn, and the name of the licensed individual who withdrew and administered the
26 medication. Each user/operator is given a user identification code to operate the control panel.
27 Sometimes only portions of the withdrawn medications are administered to the patient. The
28 portions not administered are referred to as "wastage." Wasted medications must be disposed of
in accordance with hospital rules and must be witnessed by another authorized user and recorded
in Pyxis.

² Stacking occurs when an order for a controlled substance is obtained from one physician,
then a new order for a controlled substance is obtained from another physician for the same
patient/same condition.

1 withdrew a 2 mg. dose and a 4 mg. dose of morphine from Pyxis at 15:40 and administered both
2 doses to the patient at the same time, for a total of 6 mg. morphine, which exceeded the
3 physician's orders. Respondent failed to document the patient's pain scale prior to administering
4 the medication. Respondent exceeded her scope of practice as a registered nurse, and practiced
5 medicine without a license when she prescribed narcotics in excess of the physician's orders.

6 22. Patient 6: On June 20, 2010, at 13:09, this patient received a physician's order for 4
7 mg. morphine and 0.5 mg hydromorphone. Respondent withdrew both the morphine and
8 hydrocodone from Pyxis at 13:17, which is a departure from standard practice since both doses
9 should not be administered simultaneously. Respondent failed to document the patient's pain
10 scale. Respondent recorded in the MAR that the patient refused the morphine. Respondent did
11 not return the 4 mg. morphine to Pyxis, and she did not record it wasted. Respondent failed to
12 account for 4 mg. morphine.

13 23. Patient 8: On June 25, 2010, at 16:58, this patient received a physician's order for 2
14 mg. morphine every 20 minutes as needed for pain. At 17:22, Respondent withdrew two 2 mg.
15 doses of morphine from Pyxis, exceeding the physician's orders, and recorded in the patient's
16 MAR that 2 mg. morphine was administered at 17:19. The remaining 2 mg. morphine was not
17 returned to Pyxis and it was not wasted. Respondent withdrew two more 2 mg. doses of
18 morphine from Pyxis at 18:02 and 18:04, respectively, and recorded 4 mg. morphine administered
19 at 18:16, exceeding the physician's orders. Respondent failed to document the patient's pain
20 scale prior to administering the medications. Respondent exceeded her scope of practice as a
21 registered nurse, and practiced medicine without a license when she prescribed twice the dose
22 ordered by the physician. Respondent failed to account for 2 mg. morphine.

23 24. Patient 9: On June 26, 2010, at 10:45, this patient received a physician's order for 2
24 mg. morphine every two hours as needed for pain, or 4 mg. morphine every four hours as needed
25 for pain. At 11:16, Respondent withdrew a 4 mg. dose of morphine from Pyxis. At 11:17,
26 Respondent withdrew a 2 mg. dose of morphine from Pyxis. Respondent recorded in the patient's
27 MAR that at 11:15, she administered both doses of morphine, for a total of 6 mg., which
28 exceeded the physician's order. At 13:44, the physician ordered 4 mg. morphine. Respondent

1 withdrew two 4 mg. doses of morphine at 14:42, double the physician's order, and recorded in the
2 patient's MAR that she administered 4 mg. morphine at 14:44. Respondent withdrew a total of
3 14 mg. morphine, and recorded 10 mg. administered. Respondent failed to document the
4 patient's pain scale prior to administering the medication. Respondent exceeded her scope of
5 practice as a registered nurse, and practiced medicine without a license when she prescribed
6 narcotics in excess of the physician's orders. Respondent failed to account for 4 mg. morphine.

7 25. Patient 10: On June 26, 2010, at 18:29, this patient received a physician's order for 1
8 mg. hydromorphone. At 18:22, Respondent withdrew 2 mg. hydromorphone from Pyxis.
9 Respondent documented in the patient's MAR that he refused the medication. Respondent
10 recorded 1 mg. hydromorphone wasted. Respondent failed to account for 1 mg. hydromorphone.

11 DOI Interview with Respondent

12 26. In an interview with Respondent on April 25, 2012, Respondent told the DOI
13 investigator that she did not take any controlled substances from the workplace. Respondent
14 admitted that she overmedicated Patient 5 (paragraph 21, above), claiming she was advocating for
15 the patient because the patient was in pain and the prescribed dose was not enough. Respondent
16 stated that she received a verbal approval to increase the morphine dose for Patient 8 (paragraph
17 23, above), but that she did not properly document it because she was probably ready to finish her
18 shift. Respondent had no explanation for the missing 20 mg. morphine and 1 mg.
19 hydromorphone.

20 Division of Investigation Case No. 11-03790-RN

21 27. On June 20, 2011, the Board received a complaint from the Associate Chief Nursing
22 Officer at Inland Valley Medical Center (IVMC) stating that Respondent's employment was
23 terminated after multiple discrepancies involving medication administration were discovered.
24 Respondent had been employed in the IVMC Emergency Department and had not yet completed
25 her 90-day probationary period as a full-time employee at the time of her termination.
26 (Respondent had previously worked at IVMC as a registry nurse.)

27 28. As an employee of IVMC, Respondent received training in and was responsible for
28 implementing IVMC's protocols. Specifically, Respondent was responsible for adhering to

1 policies and procedures entitled "*Substance Abuse*," "*Key Issuance*," "*Sedation*," "*Medication:*
2 *Ordering, Transcription and Administration Of*," "*Medications: Self Administration Of*,"
3 "*Automated Drug Dispensing Systems*," "*Controlled Substance: Processing and Security*,"
4 "*Controlled Substances*," "*Disposition of Medication in the Pharmacy*," and "*Controlled*
5 *Substances: Procedures for Loss/Theft*."

6 29. As a result of the complaint, the Division of Investigation (DOI) commenced an
7 investigation of the allegations. The Associate Chief Nursing Officer told the DOI Investigator
8 that they first learned of the medication discrepancies after the IVMC pharmacy generated its
9 monthly Pyxis report. The discrepancies were attributed to Respondent are as follows:

10 30. Patient MR No. 113869242: On April 2, 2011, at 16:20, this patient received a
11 physician's order for 1 mg. Dilaudid (hydromorphone). Respondent withdrew 1 mg. Dilaudid
12 from Pyxis at 17:16. Respondent failed to document the administration of the Dilaudid in the
13 patient's MAR, and no wastage was recorded. Respondent failed to account for 1 mg. Dilaudid.

14 31. Patient MR No. 113871081: On April 3, 2011, at 11:58, this patient received a
15 physician's order for 0.5 mg. Dilaudid. Respondent withdrew four 1 mg. doses of Dilaudid from
16 Pyxis at 12:10, 13:09, 15:15, and 16:02. Respondent recorded in the patient's MAR that 0.5 mg.
17 Dilaudid was administered at 12:17, 13:12, and 17:02. No wastage was recorded for the leftover
18 Dilaudid. Respondent failed to account for 1.5 mg. Dilaudid.

19 DOI Interview with Respondent

20 32. In an interview with Respondent on January 12, 2012, Respondent told the DOI
21 investigator that she did not take any controlled substances from the workplace. Respondent
22 attributed the majority of her documentation errors to computer malfunction, or being too busy.
23 Respondent admitted that she wasted medications without a witness. Respondent had no
24 explanation for the missing 2.5 mg. Dilaudid. Respondent stated that she would sometimes throw
25 leftover medication in the trash located next to the patient's bed when she was too busy to waste.

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1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Incompetence)**

3 33. Respondent has subjected her registered nurse license to disciplinary action for
4 unprofessional conduct under section 2761, subdivision (a)(1) in that she was incompetent, as
5 defined by Title 16, California Code of Regulations, section 1443, in that while employed at
6 Kaiser Permanente and Inland Valley Medical Center, as described in paragraphs 16-32, above,
7 Respondent repeatedly demonstrated she did not possess the degree of learning, skill, care and
8 experience ordinarily possessed and exercised by a competent registered nurse. Respondent acted
9 outside the scope of her practice when she removed more medication from Pyxis than was
10 ordered by the physician, and administered medication in excess of the physician's orders.
11 thereby jeopardizing patient safety. Respondent failed to account for medications removed from
12 Pyxis. Respondent failed to abide by her employers' policies and procedures regarding
13 medication administration. Respondent routinely failed to conduct a pain assessment before
14 administering medications. Respondent admitted she wasted medications in the patients' bedside
15 trashcan. Respondent's conduct is a departure from acceptable standards of practice for a
16 registered nurse.

17 **SECOND CAUSE FOR DISCIPLINE**

18 **(Unprofessional Conduct)**

19 34. Respondent has subjected her registered nurse license to disciplinary action for
20 unprofessional conduct under section 2761, subdivision (a) in that while employed at Kaiser
21 Permanente and Inland Valley Medical Center, as described in paragraphs 16-32, above,
22 Respondent repeatedly failed to properly handle controlled substances, and violated the protocols
23 of each hospital with respect to the administration of medications.

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THIRD CAUSE FOR DISCIPLINE

(Illegal Administration of Controlled Substances)

35. Respondent has subjected her registered nurse license to disciplinary action under section 2762, subdivision (a) of the Code for unprofessional conduct in that on multiple occasions, as described in paragraphs 16-32, above, Respondent furnished controlled substances to patients that were not prescribed by a licensed physician.

FOURTH CAUSE FOR DISCIPLINE

(Inaccurate Documentation in Hospital Records)

36. Respondent has subjected her registered nurse license to disciplinary action under section 2762, subdivision (e) of the Code for unprofessional conduct in that on multiple occasions, as described in paragraphs 16-32, above, Respondent falsified, or made grossly incorrect or grossly inconsistent entries in hospital, patient, and Pyxis records pertaining to controlled substances prescribed to patients.

FIFTH CAUSE FOR DISCIPLINE

(Administering Controlled Substances Without a Physician's Order)

37. Respondent has subjected her registered nurse license to disciplinary action under section 2761, subdivision (d) of the Code for unprofessional conduct in that on multiple occasions, as described in paragraphs 16-32, above, Respondent administered to patients controlled substances without an order from a licensed physician, in violation of Code section 2725, subdivision (b)(2).

SIXTH CAUSE FOR DISCIPLINE

(Practicing Medicine Without a License)

38. Respondent has subjected her registered nurse license to disciplinary action under section 2761, subdivision (a) of the Code for unprofessional conduct in that on multiple occasions, as described in paragraphs 16-32, above, Respondent engaged in the practice of medicine when she prescribed controlled substances to patients, as is prohibited by section 2052 of the Code.

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1 **PRAYER**


2 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
3 and that following the hearing, the Board of Registered Nursing issue a decision:

4 1. Revoking or suspending Registered Nurse License Number 508931, issued to
5 Angelina Lilly Ortiz;

6 2. Ordering Angelina Lilly Ortiz to pay the Board of Registered Nursing the reasonable
7 costs of the investigation and enforcement of this case, pursuant to Business and Professions
8 Code section 125.3;

9 3. Taking such other and further action as deemed necessary and proper.
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12 DATED: SEPTEMBER 26, 2012

13 *for* 
14 LOUISE R. BAILEY, M.ED., RN
15 Executive Officer
16 Board of Registered Nursing
17 Department of Consumer Affairs
18 State of California
19 Complainant
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